ANNUAL REPORT

Assessment and Placement Service

Hamilton, Ontario

APS

1981 - 82

TENTH ANNUAL REPORT
OF THE
ASSESSMENT AND PLACEMENT SERVICE
HAMILTON, ONTARIO

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	Ms. V. Watson **

* Resigned April 1981
** Appointed April 1981

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HISTORICAL BACKGROUND

The A.P.S. was established by the Hamilton District Health Council in 1971 on the advice of the then newly formed Extended Care Committee. The project was funded in April of that year by the Ontario Ministry of Health and commenced operation in September 1971.

One of the concerns of the Health Council has been the promotion of optimal utilization of the services for the disabled and chronically ill. The Extended Care Committee was formed to study the needs of this group and the services available. The result of their discussions was the recommendation that a coordinating body be formed to obtain the medical, social and nursing evaluations of the disabled and chronically ill and make recommendations of the appropriate programs or levels of care for the development of the individual's assets and potential.

The Health Council appointed a medical consultant and two members of the health professions to provide the coordinating evaluation function; a part-time administrator and secretarial staff; and a data analyst to maintain statistics for the evaluation of the service's efficacy and the provision of an information base for future planning in the health needs of the disabled.

ASSESSMENT FORM

Prior to commencement of operation an Assessment tool was developed to provide the necessary information for appropriate recommendation. Broadly, this information falls into three categories:

(a) demographic (age, sex, marital status, next-of-kin, education, employment and cultural background, present location and level of income)

(b) medical (diagnosis, prognosis, treatment, level of cognitive function, emotional status)

(c) functional capacity (degree of ability to walk, talk, see, hear, comprehend, dress, bathe, undertake personal care and household care.)

The demographic and functional capacity data is provided by a social worker-nurse team for the hospitalized applicant and by the Public Health, Victorian Order or St. Elizabeth Nurse for those applicants at home. The medical information is provided by the applicant's personal physician.

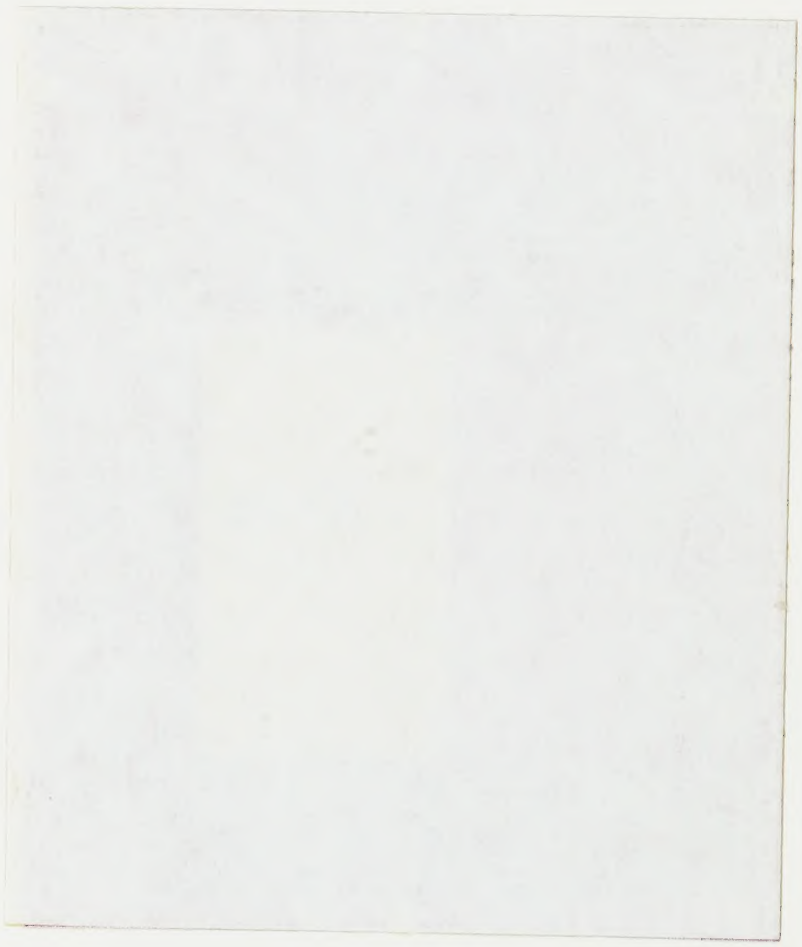
RECOMMENDATIONS

Recommendations are made on the basis of the information provided by the Health Care team with additional input as indicated and with an intimate knowledge of the available facilities and programs.

Recommendations include appropriate level of care, and/or programs of rehabilitation or recreation, and programs whereby the disabled person may be assisted toward a meaningful role in society.

REFERRAL PROCESS

Referrals are made by health professionals in the community or health care institutions and/or members of the community, and may be as simple as a telephone call asking for the process to be set in motion.



MEDICAL CONSULTANT'S REPORT

The Role of A.P.S. in Support of Health Planning

- J.R.D. Bayne, M.D., F.R.C.P. (C), F.A.C.P. -

The Assessment & Placement Service was established by the Hamilton Wentworth District Health Council in September 1971. Its primary purpose was and still is, to assist disabled persons and the health professionals caring for them, to find appropriate institutional or community support services according to their identified needs. While initial application may be made by the person him/herself or the family or friends, the detailed information on diagnosis, treatment, functional ability and care needs are provided by the personal physician, the nurse and other professionals involved in hospital or at home. This information is recorded on a standardized two-part form which was developed with the help of the referring professional groups and the receiving institutional staffs, and with advice from the McMaster Department of Clinical Epidemiology and Biostatistics. The A.P.S. counsellor uses the information on the form, perhaps augmented by telephone discussion with the referring professionals, for discussion with the staff of the institutions or services that seem appropriate. Any questions and then acceptance by them are related back to the referring professionals with appropriate recommendations for action. Major points of information on the form, the action recommended and action actually taken, are coded and stored on computer tape.

The use of a standardized form enables A.P.S. to gain a cumulative picture of the demands and needs for various types of services and to build up the evidence of utilization. The communication with the receiving institutions and services enables A.P.S. to learn of the problems in providing care and the gaps in services. Thus the components are in place for ongoing health needs assessment. The Guide to Health Needs Assessment published by the Canadian Public Health Association (1) defines these components as follows:

- wants: services expected by the public
- needs: services that should be provided according to experts based on health status information about target groups
- demand: types and amount of health services requested by the public after being aware of costs
- use: the services actually utilized
- supply: the quantity of services available in numbers and distribution

  the quality of services available (ability of services to meet the needs of individuals).

Although the professionals are only obliged to use A.P.S. for chronic hospital admission, the long term care institutions have encouraged its use by applicants because of the information that this makes available to them in deciding if they can give sufficient care. This means that information on the wants, needs and demand from the population of Hamilton Wentworth for long term care is available from A.P.S. and is always current. The use and supply of resources to respond to the needs and demands and the gaps and deficiencies in service are also readily available and up to date.

The capability to supply reliable up to date information has proven of use in the development of the Geriatrics/Gerontology Program in the Hamilton Wentworth District. In 1971 the availability and quality of chronic hospital type of care was very limited. The Board of Directors of the then St. Peter's Infirmary recognized that the obsolete buildings must be replaced and that a larger and modern facility was needed. The limited programs and services then provided were clearly inadequate. But reliable information was missing on what types and numbers of patients needed chronic hospital type of care, what services and staff would be needed and what physical plant would be appropriate.

The development and growth of A.P.S. provided detailed consistent information on the needs of each individual. A picture emerged of those whose care needs were too great to be met adequately by such long term care facilities as Nursing Homes and Homes for the Aged or by families. As the details were analysed it became apparent that this group consisted of persons with multiple care needs that could only be properly assessed and treated by a multidisciplinary team working cooperatively together. In most cases the diagnosis was already established and further diagnostic technical procedures were not needed. Each of these persons required a variety of different services. On further analysis there were found to be categories of persons within the chronic care group that had similar special characteristics and care requirements.

With this information it was possible for St. Peter's to design special programs for the various categories, and to identify the space and facilities necessary for them. On analysing the provision and availability of personal institutional care of the type provided in nursing homes and Homes for the Aged, it became apparent that this type of care could be provided by existing or planned services and need not be undertaken by St. Peter's. What was needed was a facility that accepted persons requiring a great deal of physical care, control of disturbed behaviour, long term reactivation, terminal care, respite care to relieve families for a holiday and urgent placement for persons whose usual care-giver at home became ill or unable to cope. There was need for separate facilities for the elderly and for the younger severely disabled because of their different life styles. Arrangements were made for a chronic hospital located in proximity to the regional rehabilitation centre to accept and focus on the younger disabled group.

Also needed was a Day Therapy Centre for support of elderly persons with care needs who were still being managed at home. The new St. Peter's Centre was then built for the elderly on an innovative design emphasizing openness, colour and light but also providing extensive care, protection and social activation. There are two major components; the in-patient services and the day therapy services.

The family physician was and is encouraged to join the medical staff and continue caring for his patient in association with the team. Thus the physician follows through after admission on the intentions initiated by applying to A.P.S.

The enlargement of St. Peter's from 180 to 284 beds was not sufficient to meet the need for chronic hospital care as the elderly population grew. The detailed information from A.P.S. identified how many more places were needed and the Ministry of Health authorized the opening of small 30-35 bed chronic care units in 2 acute care hospitals. The residents of a small, private chronic hospital were also transferred to a chronic care unit in an acute care hospital. Access to these beds is controlled through A.P.S. to ensure their appropriate use.

The use of A.P.S. information to identify and clarify the needs of special categories of patients allowed for special support actions. The Home Care program helps a large number of disabled persons to remain at home. However, if the caregiver becomes ill or unable to cope, then immediate placement is needed for the disabled person. There were found to be over 60 persons on Home Care for whom there would be no one to cope if the caregiver became ill. This situation created anxiety and families began to consider long term institutional care. After discussion the chronic and long term care facilities indicated a willingness to respond at once where the caregiver suddenly became unable to cope, by admitting the disabled person. Such assurance enables families to continue their care with greater confidence.

Other special categories that have been identified are severely disabled persons needing highly technical life support services and young persons needing long term personal care and special support such as provided by nursing homes but who should not be placed in institutions with large elderly populations. (2) Also there are those confused elderly persons who, because of continued ability to ambulate, are at special risk and need non-restrictive protection and care. Programs responding to these needs are still to be developed. (2)

In 1979 the Hamilton-Wentworth District Health Council set up a Task Force to study the provision of long term care. The accumulated experience and data from the A.P.S. allowed for accuracy and detail in reviewing existing resources and future requirements. Such information is useful also in correcting misapprehensions among the practising health professionals. Not unreasonably, a professional group tend to judge the effectiveness or adequacy of a service from their own experience. Problem cases impress us more than those that are managed easily in the system, and we tend to exaggerate the numbers or importance of those cases in planning for future needs. The A.P.S. data has repeatedly been helpful in showing whether or not the apparent problem is real, and if the problem does exist, in showing its dimensions.

In summary, the A.P.S. system provides the means to identify and record the demands and needs for services by individuals and groups, to monitor utilization, adequacy and deficiencies, and provides the reliable detailed and up to date information required for planning.

References:

(1) Guide to Health Needs Assessment:
A Critique of Available Sources of Health and Health Care Information
Canadian Public Health Association
1335 Carling Avenue, Suite 210
Ottawa, Ontario K1Z 8N8

(2) A.P.S. Annual Reports, Administrator's Report 1976-81.

ADMINISTRATOR'S REPORT

Joyce Caygill

This is the last Annual Report which will use the name Assessment and Placement Service. On April 1, 1982, after eleven years as A.P.S., this service will be known as the PLACEMENT COORDINATION SERVICE (P.C.S.).

Also on that date the Victorian Order Nurses will become the contracting agency for the service. The operation will remain the same, the staff and location will not change, however, we anticipate even greater opportunities to be of service to the community under the wing of the V.O.N. A.P.S. has had a long and productive cooperation with the V.O.N. and its other operating units: the Home Care Programs (active and chronic maintenance), Meals on Wheels and the Friendly Visitors Volunteer Program; in fact, V.O.N. nurses complete approximately 13% of our referral forms and initiated 236 of the referrals in the data base of this Report.

The material used for this Report was collected during the fiscal year April 1, 1981 to March 31, 1982.

The numbers of persons referred to A.P.S. remained relatively steady, slightly less than 1980-81 which was our highest year to date. Forty new chronic care beds were opened during the year bringing the official total to 469. An additional 39 nursing home beds were opened in two homes with an additional 61 planned for the end of 1983.

Dr. Bayne has mentioned the use of a system of "categorization" of the differing nursing care patterns in chronic care institutions which was developed with the assistance of the A.P.S. data. The percentages of persons in each category, both in chronic care institutions and on the waiting list remain remarkably constant, and provide valuable indicators of the number of beds which should be allocated to each "category." Similarly, the percentage of persons referred to A.P.S. who are both confused and self mobile is predictable. Just over 14% of our total caseload was devoted to this group in 1981-82. (see Table V1). However, the number of beds allocated specifically to this group is only 4% of the total long term care pool.

In the last Annual Report mention was made of the Family Assistance, or respite, program in chronic care units (see also p.11 of this Report). This program has enabled many families to remain intact and has helped caregivers to continue to manage their disabled relatives at home, many of whom are at the Type 3 level of care.

DATA BASE

Criteria for inclusion in the data base for this Report were as follows:

- Parts A and B of the A.P.S. referral form had been completed by the attending health professionals.

- the care needs identified by attending health professionals had been "matched" with care provided in various programs and a recommendation of the appropriate program had been made and recorded by A.P.S.

- either placement, death, refusal of placement, change of condition or refusal of patient by a program had occurred to close the case.

One thousand nine hundred and forty cases fulfilled these criteria and were used for the majority of the information in the Report.

REFERRALS

During the 1981-82 fiscal year we were involved with 3228 cases. 2806 were referred during the year and 422 had been transferred, unplaced, from the 1980-81 caseload. On March 31, 1982, 621 cases were transferred, unplaced, to the 1982-83 waiting list, and 323 cases on which a recommendation had not yet been made transferred to the 1982-83 caseload. Of the remainder (2284) 1940 cases have been used for this report, 344 either died or decided against placement before a recommendation could be made.

WAITING LISTS

The waiting list has shown another decline to the level of 1976 when a monthly average of 540 awaited placement. An additional 40 chronic care beds were added to the system during the year; 30 at St. Joseph's Hospital and 10 at the Chedoke Continuing Care Centre.

Table I shows the total number awaiting placement at time of the monthly census.

Monthly average awaiting placement:

1976	- 540
1977	- 617
1978/79	- 643
1979/80	- 672
1980/81	- 615
1981/82	- 540

PLACEMENTS

Of the 1940 persons in the data base, 251 died before placement, 492 refused placement when it was available, 203 underwent a change in condition and 24 were refused admission to a specific facility. In each of the 24 we had recognized that suitable programs for their needs did not exist, however, it is A.P.S. policy to request that, whenever possible, programs be modified. In many instances such modifications can, and do, occur. However, for the 24 under discussion, this was not possible.

Table III shows the numbers and type of recommendations which were made and the numbers of placements obtained. As in the past three years some persons were encouraged to stay at home with the support of the Home Care program, although their care needs were appropriate for institutional care. Forty-seven persons were in this group in 1981-82. (1980/81 - 48; 1979/80 - 27; 1978/79 - 28).

In addition to permanent placement it will be noted that 96 persons were placed in chronic care facilities on a temporary basis in order to provide either an opportunity for the caregiver (usually spouse) to have a vacation, or to undergo care needs themselves. Usually these "family assistance" placements are pre-planned, however, in situations where the caregiver requires immediate medical treatment, the placement can be arranged to commence immediately.

Use of this program has been steadily increasing; it is not yet known at what number it will plateau.

The normal care sections of the homes for the aged offer a "vacation" or temporary placement program; to date nursing homes, although willing to participate, have not been able to provide accommodation for this purpose.

TYPES OF CARE REQUIRED

Table I shows the ages of persons in the data base.

Table VII shows the assessing health professionals records of ambulation and memory. A.P.S. usually considers a person to be "confused, ambulant" when confusion is recorded at level 4 or 5 (marked confusion, no recall), ambulation is recorded at levels 1 to 3 (fully ambulatory, ambulant with cane, independent with a wheel-chair). 296 persons in the data base were in this category.

514 referrals were completed by hospital residents or interns, the remainder were completed by family physicians with an average of four per physician.

233 persons had been in active treatment hospitals twice within the previous twelve months; 81 had been admitted three times; 27 had had four admissions and 17 had been in hospital between 5 and 8 times in the immediately preceding 12 months.

260 persons were referred by family members, 134 by their physicians, 808 by hospital teams, 236 by V.O.N., 171 by P.H.N. and 306 from other persons in the community; missing data: 25. 58% of referrals were from the community.

836 (43%) were male, 1104 (57%) were female. 680 persons were married at the time of referral, the remainder were widowed, divorced or single. Missing data: 72. 88 persons could not speak English (4.5%).

42 persons required oxygen; 144 had indwelling catheters; 92 required sterile dressings; 29 required intravenous feeding, 31 required tube feeding; 497 required a special diet.

994 required assistance during the night. 397 had limited to poor vision, and 19 were blind. 357 had partial to poor hearing, and 10 were deaf.

1490 persons did not smoke; 258 expressed an interest in having alcoholic beverages available on an occasional or regular basis.

CLIENT SATISFACTION

A.P.S. conducts a follow-up by mail and/or telephone four to six weeks after placement. Of the 1040 persons who were placed in 1981-82, 788 responded as follows:

Client/family satisfied	Yes: 749	No: 35	(missing: 4)
Facility satisfied with client	Yes: 777	No: 8	(missing: 3)
A.P.S. Counsellor satisfied	Yes: 762	No: 26	

"No" responses are checked immediately by A.P.S. to determine the cause of dissatisfaction and to effect changes if possible.

IDENTIFICATION OF NEEDS IN THE COMMUNITY

A.P.S. data was used extensively by the Long Term Care Task Force of the Hamilton Wentworth District Health Council for its Report published February 1982.

The Task Force recommendations pay particular attention to the needs of the young, disabled who require care at the Type 2 (nursing home) level and the confused but self mobile elderly; both groups have been consistently mentioned in these annual reports. In addition, the Task Force recommends specific attention to the needs of the young adult who is severely disabled and profoundly mentally retarded (see 1980-81 Report on Rygiel Home), and to additional transportation opportunities for the disabled and aged.

Other recommendations relate to day programs, physical and psychiatric assessment, additional bed requirements and home support services.

TABLE I

AGE AT TIME OF REFERRAL

	1981-82	1980-81	1979-80
5 - 9	2	0	1
10 - 14	2	1	3
15 - 19	13	11	7
20 - 24	5	19	4
25 - 29	3	13	7
30 - 34	4	13	8
35 - 39	5	5	6
40 - 44	11	10	11
45 - 49	17	19	17
50 - 54	43	50	42
55 - 59	54	49	39
60 - 64	112	108	104
65 - 69	148	192	118
70 - 74	266	258	193
75 - 79	354	376	330
80 - 84	363	480	378
85 - 89	317	378	295
90 - 94	152	148	129
95 - 99	44	51	40
100 - 104	16	12	9
Missing data:	7	6	21

TABLE II

LOCATION AT TIME OF REFERRAL

HAMILTON-WENTWORTH	
Henderson Hospital	165
Hamilton General Hospital	182
St. Joseph's Hospital	198
*Chedoke Division	87
*McMaster Division	97
St. Peter's Hospital	16
Hamilton Psychiatric Hospital	21
Community	943
HALTON	
Hospitals	114
Community	66
ONTARIO	
Hospitals	12
Community	33
CANADA	2
missing data:	4
TOTAL	1940

*Locations of Chedoke-McMaster Hospital.

TABLE III

RECOMMENDATION & PLACEMENT

Number of places required		Number placed
Hamilton - chronic	439	224
Halton - chronic	47	8
other areas - chronic	9	3
*Family assistance - chronic	104	96
Life support	5	
Hamilton - nursing homes	696	306
Halton - nursing homes		27
other areas - nursing homes		19
Homes for aged - normal	279	59
- special	87	22
- bed	13	1
- couples	28	9
* - vacation	4	1
- Foster	2	1
Lodging Home	49	88
Home Care	19	63
other home supports	1	11
Day centres	117	57
Rehabilitation - Hamilton	1	7
- Halton	1	0
Assessment	9	4
Other	35	8
TOTAL	1940	1040

* Various names for respite/vacation relief beds.

TABLE IV

MONTHLY CENSUS OF WAITING LIST

Hamilton-Wentworth and Burlington

	Waiting List at Monthly census		Number awaiting Nursing Home		Number awaiting Chronic Care *	
	80/81	81/82	80/81	81/82	80/81	81/82
April	660	420	259	108	122	111
May	691	422	272	124	135	107
June	658	516	256	158	121	111
July	653	499	232	150	140	117
August	629	523	225	157	132	127
September	672	572	242	175	141	120
October	684	602	259	190	130	128
November	623	591	239	187	110	116
December	557	566	209	176	107	112
January	527	595	167	204	123	106
February	542	589	169	214	146	97
March	489	593	134	208	99	77

* does not include those awaiting family assistance/vacation/respite.

TABLE V

FIVE YEAR COMPARISON OF WAITING LISTS FOR THE MONTH OF NOVEMBER

In institutions awaiting placement

Facility required	1977	1978	1979	1980	1981
Nursing Homes	157	128	141	112	79
Chronic Hospitals	88	116	95	80	88
Homes for the Aged	40	19	31	30	24
Rehabilitation Units	3	5	4	0	0
Community Services	16	16	2	10	3
Other	10	2	11	7	5
Total in hospital	314	286	284	239	199

In the community awaiting placement

Facility required	1977	1978	1979	1980	1981
Nursing Homes	108	140	186	115	108
Chronic Hospitals Family Assistance	30	40	71	33	28 20
Homes for the Aged	109	144	138	148	168
Rehabilitation Units	2	1	1	2	0
Community Services	23	41	43	31	46
Other	27	26	27	12	22
Total in community	299	392	466	341	392
Total awaiting placement	613	678	750	580	591

EXPLANATION OF DIAGNOSTIC GROUPINGS

In view of the fact that it is usually the physical and care needs that determine the type of care a patient requires from a program in long term care, the diagnoses have been grouped to provide a "picture" of the disease states of persons referred to A.P.S. Groups are as follows: code numbers relate to the coding system "International Classification of Diseases adapted for American use" (ICDA-8).

"Conditions related to cerebral dysfunction" - CVA, senile and pre-senile dementia, cerebral arteriosclerosis, cerebrovascular disease, senility, organic brain syndrome, affective psychoses. (Codes: 290-299, 344, 432-438, 794).

"Conditions related to cardiac dysfunction" - rheumatic heart diseases, hypertensive heart disease, ischemic heart disease, arteriosclerotic heart disease, congestive heart failure, etc. (Codes: 391, 393-398, 402, 410-429).

"Neoplastic diseases" - (Codes: 140-199, 200-209).

"Conditions classed as arthritis" - osteoarthritis, rheumatoid arthritis, arthritis, rheumatism. (Codes: 710-718).

"Hypertension" - (Code: 401).

"Diabetic conditions" - (Code: 250).

"Conditions related to respiratory dysfunction" - emphysema, asthma, bronchitis, chronic obstructive lung disease, pneumonias. (Codes: 480-493).

"Hip fractures" - (Code: 820).

"Arteriosclerosis" - (Code: 440).

TABLE VI

DIAGNOSIS

Number of diagnoses recorded 5163

Average number of diagnoses per referral 2.6

N = 1940

Diagnosis	Absolute frequency	Percentage of 5163
1 Conditions related to cerebral dysfunction	1,332	25.8
2 Conditions related to Cardiac dysfunction	634	12.3
3 Neoplastic diseases	305	5.9
4 Conditions classed as arthritis	296	5.7
5 Hypertension	296	5.7
6 Diabetic conditions	277	5.4
7 Conditions related to respiratory dysfunction	238	4.6
8 Hip fractures	132	2.5
9 Arteriosclerosis	91	1.8
	3,601	69.7

TABLE VII

MEMORY AND AMBULATION

MEMORY

AMBULATION		NORMAL 1	FORGETFUL 2	PERIODS OF CONFUSION 3	MARKED CONFUSION 4	NO RECALL 5	ROW TOTAL
Fully	1	93	132	120	164	27	536
Ambulatory with cane	2	90	124	91	39	3	347
With wheelchair	3	77	68	57	50	13	265
Requires assistance	4	99	142	155	133	30	559
Immobile	5	28	27	39	51	46	191
Row Total		387	493	462	437	119	1898

Missing observations: 42

TYPES OF CARE

(extract: Patient Care Classification by Types of Care, Ontario Ministry of Health publication #75-2222 8/75, pp3-4)

TYPE 1 (RESIDENTIAL CARE)

Care required by a person who is ambulant and/or independently mobile, who has decreased physical and/or mental faculties, and who requires primarily supervision and/or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services. The period of time during which care is required is indeterminate and related to the individual condition.

TYPE 2 (EXTENDED HEALTH CARE)

Care required by a person with a relatively stabilized (physical or mental) chronic disease or functional disability, who having reached the apparent limit of his recovery, is not likely to change in the near future, who has relatively little need for the diagnostic and therapeutic services of a hospital but who requires availability of personal care on a continuing 24 hour basis, with medical and professional nursing supervision and provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years.

TYPE 3 (CHRONIC)

Care required by a person who is chronically ill and/or has a functional disability (physical or mental) whose acute phase of illness is over, whose vital processes may or may not be stable, whose potential for rehabilitation may be limited, and who requires a range of therapeutic services, medical management and skilled nursing care plus provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years.

TYPE 4 (SPECIAL REHABILITATIVE CARE)

Care required by a person with relatively stable disability such as congenital defect, post-traumatic deficits of the disabling sequelae of disease, which is unlikely to be resolved through convalescence or the normal healing process, who requires a specialized rehabilitative program to restore or improve functional ability. Adaptation to this impairment is an important part of the rehabilitation process. Emotional problems may be present and may require psychiatric treatment along with physical restoration. The intensity and duration of this TYPE OF CARE is dependent on the nature of the disability and the patient's progress, but maximum benefits usually can be expected within a period of several months.

TYPE 5 (ACUTE)

Care required by a person:

a) who presents a need for investigation, diagnosis or for definition of treatment requirements for a known, an unknown, or potentially serious condition; and/or

b) who is critically, acutely or seriously ill (regardless of diagnosis) and whose vital processes may be in a precarious or unstable state; and/or

c) who is in the immediate recovery phase or who is convalescing following an accident, illness or injury and who requires a planned and controlled therapeutic and educational program of comparatively short duration.

TERMINOLOGY IN COMMON USE IN ONTARIO

TYPE 1 CARE

Where provided

Homes for the Aged
Charitable institutions
Nursing homes
Foster homes
Group homes
Boarding homes
Homes for special care (residential care)
Children's institutions
Homes for unmarried mothers

Terminology

Domiciliary care
Ambulant care
Normal care
Residential care
"Intermediate care" in nursing homes
Community (social) support programs
(mental)
- day care
- sheltered workshops
- supervised recreation

TYPE 2 CARE

Where provided

Homes for the Aged
Nursing homes
Homes for special care (nursing homes)
Children's institutions

Terminology

Extended health care
Extended care
Homes for special care programs

TYPE 3 CARE

Where provided

Chronic hospitals
Chronic care units in general hospitals
Nursing homes approved for chronic care
Geriatric units in psychiatric hospitals
Special facilities (schedule II) for mentally retarded with physical handicap
Children's institutions

Terminology

Chronic care
Care of the chronically ill
Chronic hospital care
Psycho-geriatric units (psychiatric hospital)

TYPE 4 CARE

Where provided

Regional rehabilitation centres

Terminology

Special rehabilitation care
Rehabilitation

TYPE 5 CARE

Where provided

Public hospitals
Private hospitals
(G.H.P.U.) psychiatric units of general hospitals
Provincial psychiatric hospitals
Private psychiatric hospitals
Community psychiatric hospitals
Children's mental health centres

Terminology

Acute care
Active treatment
Psychiatric care (short and medium term)

OPERATING EXPENSES

	Year end - *March 31/82	March 31/81
Salaries **	123,167	113,427
Employee benefits	16,642	11,986
Space costs & services	12,996	11,220
Insurance	244	244
Maintenance & Repairs	175	272
Postage	1,988	1,504
Office supplies	5,457	4,844
Telephone	3,106	2,563
Travel	1,672	1,524
Data processing	3,405	3,304
Staff training	130	85
Equipment	--	(11)
Other	57	48
Audit (est.)	500	300
	169,539	151,310

* figures prior to audit

** includes accrued staff benefits for vacation and sick leave

NOTES

Data was accessed using the Statistical Package for the Social Sciences (SPSS) software package on the HP 3000 of McMaster University Computation Services Unit.

Codes include:

Diagnosis	ICDA-8 (International Classification of Diseases adapted for American use)
Location by facility	Ministry of Health
	Ministry Information System Division
	Data Development & Evaluation Branch
	Master Numbering System
Location by area	Ontario Postal Region Code
Physician	Medical Directory of the College of Physicians & Surgeons of Ontario

ACKNOWLEDGEMENTS

We continue to enjoy the support and cooperation of the providers of health care in this area, and of McMaster University Computation Services Unit. We gratefully acknowledge their contribution to the continued operation of our service.